SINGLE BED CERTIFICATION REQUEST FORM

To be completed by CCRSN:

Facility Requesting Certification _____

Person Making Request _____ Date _____

FAX _____ Phone _____

Consumer Name _____

DOB _____ SSN _____

Legal Status _____ Dated _____

Criteria for requesting certification _____

_____

Expected benefit to the consumer as a result of approval of certification _____

_____

_____

Estimated Length of Certification _____ Days From _____ To _____

To be completed by Western State Hospital:

Certification Approved By _____

Date _____ Phone _____

FAX to: Teresa Mahar, LICSW/QMRP,WSH Director of Social Work at (253) 756-2527.